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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUTCHINSON REGIONAL MEDICAL CENTER INC (SNU)	1701 E 23RD AVE HUTCHINSON, KS 67502

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F 000	INITIAL COMMENTS The following citations represent the findings of a health resurvey. A revised copy of the 2567 was sent to the facility on 5/22/14.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during	F 156		5/9/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the

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physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:
The facility census totaled 11 residents with 10 current residents and 3 discharged residents included in the sample. Three residents were reviewed for liability notices (a notice of Medicare non-coverage). Based on interview and record review, the facility failed to include the name and phone number of the QIO (Quality Improvement Organization) for a resident to file an immediate appeal. This failure had the potential to affect all 3 residents reviewed. (#36, #29, #42)

Findings included:

- Review of the liability notice for resident #29 revealed the resident discharged from skilled services on 3/7/14 and signed the notice that the facility planned to stop the skilled services on 3/6/14.

Review of the liability notice for resident #42 revealed he/she discharged from skilled services on 11/21/13 and signed the form on 11/20/13.

Review of the liability notice for resident #36 revealed he/she discharged from skilled services

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F 156	Continued From page 3 on 12/2/13 and signed the form on 11/29/13. Under the section on "How to Ask For and Immediate Appeal", the form indicated the resident/family member should call the "QIO at: {insert QIO name and toll-free number of QIO} to appeal." The forms for all three residents did not list the QIO name or phone number. Interview on 4/24/14 at 1:45 p.m. with administrative nursing staff A confirmed the liability notices did not include the QIO name or the phone number for the resident to contact for an immediate appeal. Review of the facility policy for Expedited Review for Termination of Skilled Services, revised 3/14, revealed the notice must include the QIO contact information. The facility failed to provide the liability notice to the residents to include the QIO name and phone number to appeal.	F 156		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.	F 167		5/9/14

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F 167	Continued From page 4 This REQUIREMENT is not met as evidenced by: The facility census totaled 11 residents. Based on observation, interview, and record review, the facility failed to post the most recent facility Federal and State survey results. This failure had the potential to affect all residents residing in the facility. Findings included: - Observation at 9:00 a.m. on 4/22/14 revealed a sign on the bulletin board near the entrance to the nursing unit stating Kansas Department on Aging Survey Results. It did not indicate a separate location of the survey results. The only survey results posted included a single laminated sheet of paper from a survey completed in 2011 that indicated the facility did not have any deficiencies. Interview on 4/22/14 at 9:02 a.m. with administrative nursing staff A revealed the survey results were in a drawer in his/her desk. Staff A reported the facility did not keep or post a copy of the Life Safety Code (environmental Federal and State inspection) but could find one if needed. Interview on 4/22/14 at 9:05 a.m. with administrative nursing staff G revealed he/she only knew of the survey results posted on the bulletin board near the entrance. Staff G reported he/she did not know of any other survey results or where they were located. Review of the facility policy for Survey Results, dated 4/14, revealed the most recent Kansas Department of Aging and Disability Services survey results, Life Safety Code survey results, and plan of corrections must be readily available	F 167		

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F 167	Continued From page 5 at all times to family and residents. The facility failed to post the most recent Federal and State survey results for residents.	F 167		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: The facility census totaled 11 residents with 13 residents included in the sample, three of which were closed records. Based on observation, interview, and record review, the facility failed to provide an ongoing program of activities to meet the interests of 2 of 3 residents reviewed for activities. (#74 and #71) Findings included: - According to resident #74's admission assessment the resident was admitted on 4/21/14. The resident was alert and oriented to person, place, times, and event. The resident required partial assistance of two persons for mobility. The resident had appropriate affect and cooperative behavior and he/she could make his/her needs known. Review of a nursing shift assessment from 4/24/14 at 9:45 AM revealed the resident was alert and oriented to person, place, time, and	F 248		5/29/14

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event. The resident had a steady gait and required partial assistance of one person for mobility.

Review of the activities care plan dated 4/21/14 revealed goals for the resident to attend activities, participate in activities available on the unit, minimize boredom, and to have the resident's social needs met. Interventions included to assess the resident's activity activity preferences and needs, encourage participation, assist with ambulation. It directed staff to see Activity Plan of Care. The care plan lacked a specific activity plan of care, though staff were directed to reference one.

Observation on 4/22/14 at 4:05 PM revealed the resident sat talking in his/her room with a visitor.

Observation on 4/23/14 at 8:56 AM revealed no schedule of activities noted through out the unit or in the resident's room.

Interview with administrative nursing staff A on 4/22/14 at 8:00 a.m. revealed the activity director was out on surgical leave.

Interview with the resident on 4/23/14 at 8:02 AM revealed he/she did not know if there were any other activities planned for the day. The resident reported activities were not provided as often as he/she would like.

Interview with the resident on 4/23/14 at 12:00 PM resident reported he/she did not really feel there were enough activities available to keep him/her busy and from being bored. The resident reported he/she asked a family member to bring him/her a puzzle book as he/she liked to do them,

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but the staff had not offered to provide any.

Interview on 4/23/14 at 11:00 AM with direct care B revealed the for activities, staff offered to walk the resident in the hall. Staff B reported the resident was very quiet and his/her family member stayed in his/her room all the time and the resident enjoyed spending time with them. Staff B reported the resident also watched TV a lot. Staff B reported the activities director talked with residents and offered books and puzzles, but did not really do any activities outside the residents' rooms.

Interview on 4/24/14 at 4:28 PM with licensed nursing staff E revealed he/she did not know if anyone had taken over the activities program while director was gone. Staff E reported the facility used to do a big activity calendar but that went by the way side when new administration came in. Staff E reported the facility did not do group activities, but all residents had a TV. Staff E reported the facility had crosswords and puzzles, books, and received the newspaper daily. Staff E reported occasionally singing groups came by.

Interview on 4/24/14 at 5:00 PM with administrative nursing staff A revealed the dining room was available for all residents to do activities, but no one utilized it much. Staff A reported activities were not offered by activities director due to his/her job mostly involved going around and interviewing the residents to find out about their preferences and what activities they liked.

Review of the facility's policy for Activity Program, revised 3/14, revealed the following, the Skilled

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Nursing Unit (SNU) provided activities in individual and/or group settings for both ambulatory and non-ambulatory residents to provide diversion and motivation. The activity program needed to be directed by a qualified activity professional who had completed training course approved by the Kansas Department for Aging and Disability Services. The activity director planned daily activities, provided the resident with activities, and prepared activities so nursing staff may carry out the activity in the absence of the activity director. The nursing staff needed to check the daily activity calendar and offer activities to residents. The activity director needed to develop and post a monthly activity schedule available to all residents, staff, and visitors. The activity program assessment would be completed on each resident by the activity director including the resident's use of free time, preadmission hobbies and interests, the resident's ability to participate in structured individual and group activities, and identification of way to enhance the resident's activity skills.

The facility failed to offer the resident puzzle books or activities to meet his/her needs and interests.

- Review of resident #71's signed admission order sheet dated 4/19/14, revealed a diagnosis right total hip replacement.

Review of the Admission General Nursing Assessment dated 4/19/14 revealed the resident was alert and oriented to person, place, time, and event. The resident had appropriate verbal responses. Activities had not been addressed. The resident admitted on 4/9/14.

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Review of the Nursing Shift Assessment dated 4/23/14 revealed the resident was alert and oriented to person, place, time, and event. The resident had appropriate verbal responses, he/she was cooperative. This assessment did not address activities.

Review of the resident's care plan for Activities initiated 4/19/14 revealed interventions directed staff to assess activity preferences and needs, and encourage participation in activities. An intervention directed staff to refer to the Activity Plan of Care which had not been completed at that time. Interventions alerted staff that the resident read the newspaper, watched television, and participated in occupational and physical therapy.

Observation on 4/23/14 at 3:11 p.m. revealed the resident sat in his/her recliner and watched a television program. The resident reported he/she went on a walk earlier.

Observation on 4/24/14 at 10:00 a.m. revealed the resident sat in his/her recliner and watched a television program.

Interview on 4/22/14 at 10:58 a.m. with the resident revealed the resident had not been offered by staff to participate in activities and he/she had not been told by staff that there were activities like books or cards he/she could do on his/her own.

Interview on 4/23/14 at 11:41 a.m. with the resident revealed staff had not asked the resident about activities. He/she would participate depending on what the activity. He/she liked to embroider, crochet, knit, and do crafts. He/she

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reported he/she would not require assistance with activities.

Interview on 4/23/14 at 12:31 p.m. with direct care staff B revealed the activity director went around and found out the residents' hobbies. The facility had several individual activities for residents and no group activities. Staff B did not know if anyone offered activities in director's absence. He/she reported the activity director was on surgical leave. Staff B reported the resident watched a couple shows, read the newspaper, walked hall. The resident had not said he/she wanted to do anything else.

Interview on 4/23/14 at 3:58 p.m. with direct care staff H revealed the resident liked to read and walk in the halls. Staff H reported the resident stayed in his/her room to watch television and talk on phone. He/she did not know if someone replaced the activities director during the activity director's absence. Staff H reported he/she could tell if the resident was bored and offered the resident activities.

Interview on 4/23/14 at 3:28 p.m. with licensed nursing staff C revealed he/she did not know if someone took over for the activity director during the activity director's absence and may be MDS (minimum data set) coordinator did. Staff C reported the resident did not require assistance with activities of daily living and he/she did not notice the resident doing activities. The resident had his/her television on most of time.

Interview on 4/24/14 at 10:20 a.m. administrative nursing staff G revealed he/she did not know if someone took over the activities in the activity director's absence. He/she confirmed the resident

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did not have an Activity Plan of Care and reported the resident admitted to the facility on a weekend and the director was not in the facility.

Interview on 4/24/14 at 4:16 p.m. with administrative nursing staff A revealed since the activity director had been gone on surgical leave no one had replaced the activity director's duties. Staff A reported when the residents were admitted he/she encouraged the residents to go facilities where more activities were offered.

Review of the facility's policy for Activity Program, revised 3/14, revealed the following, the Skilled Nursing Unit (SNU) provided activities in individual and/or group settings for both ambulatory and non-ambulatory residents to provide diversion and motivation. The activity program needed to be directed by a qualified activity professional who had completed training course approved by the Kansas Department for Aging and Disability Services. The activity director planned daily activities, provided the resident with activities, and prepared activities so nursing staff may carry out the activity in the absence of the activity director. The nursing staff needed to check the daily activity calendar and offer activities to residents. The activity director needed to develop and post a monthly activity schedule available to all residents, staff, and visitors. The activity program assessment would be completed on each resident by the activity director including the resident's use of free time, preadmission hobbies and interests, the resident's ability to participate in structured individual and group activities, and identification of way to enhance the resident's activity skills.

The facility failed to identify, assess, and provide

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F 248	Continued From page 12 individualized activities for resident #71.	F 248		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		5/29/14

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This REQUIREMENT is not met as evidenced by:
The facility census totaled 11 residents with 13 included in the sample, three of which were closed records. Three residents were reviewed for comprehensive assessments. Based on observation, interview, and record review, the facility failed to ensure the Care Area Assessment (CAA) documentation included individualized complicating factors, risks, and any referrals for the resident as part of the comprehensive assessment for all 3 residents reviewed. (#50 and #54 for nutrition and urinary catheter use and #37 for nutrition and rehabilitation)

Findings included:

- Review of resident #50's admission Minimum Data Set (MDS) dated 12/31/13 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14 which indicated cognitively intact. The resident had a mood score of 5 which indicated mild depression. The resident required limited assistance with bed mobility, extensive assistance with transfers and walking in the room, and total dependence of staff with locomotion on and off the unit. The resident did not require assistance with eating. The resident's height was 64 inches and weight was 192 lbs with weight loss prior to admission documented as none or unknown. No oral or dental problems were identified. Resident had an indwelling urinary catheter. A urinary toileting program was not attempted. The resident admitted to the

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HUTCHINSON REGIONAL MEDICAL CENTER INC (SNU)	1701 E 23RD AVE HUTCHINSON, KS 67502

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facility on 12/24/13.

Review of the Nutritional Status CAA (Care Area Assessment) dated 1/5/14 revealed staff identified the resident at risk for inadequate nutrition and would benefit from multidisciplinary care planning to monitor and offer adequate nutrition. The description of the problem pertained to the resident not eating all meals and some weight loss recently with causes and contributing factors of decreased food intake.

Review of the ADL (activities of daily living) Functional/Rehabilitation Potential CAA dated 1/5/14 revealed the resident had a recent hip fracture and two recent falls.

Review of the Urinary Incontinence CAA dated 1/5/14 revealed the resident used an indwelling urinary catheter and had a UTI (urinary tract infection). The resident required assistance to help him/her to understand the need to have the catheter removed as soon as medically indicated and to minimize untoward effects of catheter use.

Review of the Dehydration CAA dated 1/5/14 revealed the resident was at risk for dehydration due to hospitalization and infection.

Interview on 4/24/14 at 2:02 p.m. with administrative nursing staff A revealed the purpose of the CAA was to help with the development of the care plan and he/she would have to defer all other questions to administrative staff G, as that was about all he/she knew about them.

Interview on 4/24/14 at 2:10 p.m. with administrative staff G revealed the purpose of the

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CAA was to determine why the area had triggered. Staff G reported after an area triggered, he/she went through the CAA worksheet and checked the boxes that applied and then wrote a sentence or two about why they triggered. Staff G reported he/she did not complete an individualized CAA summary.

Review of the Resident Assessment Instrument (RAI) 3.0 Manual revealed the CAA documentation helped to explain the basis of the care plan by showing how the interdisciplinary team determined the underlying causes, contributing factors, and risk factors related to the care area for a specific resident.

The facility indicated they did not have a policy regarding CAAs and instead used the RAI Manual.

The facility failed to complete the CAAs to include individualized underlying causes, contributing factors, and risk factors for this resident.

- Resident #37's closed record revealed a signed history and physical sheet dated 2/20/14, revealed the following diagnoses: anemia (a condition without enough healthy red blood cells to carry adequate oxygen to body tissues) with chronic kidney disease, diabetes mellitus (when the body cannot use glucose, there is not enough insulin made or the body cannot respond to the insulin), and End-Stage Renal Disease (ESRD-a disease condition that is terminal because of irreversible damage to vital tissues or organs pertaining to the kidney).

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Review of the resident's admission MDS (Minimum Data Set) dated 3/11/14 revealed a BIMS (Brief Interview for Mental Status) score of 15, indicating no cognitive impairment. He/she had a total mood severity score of 05, indicating mild depression. The resident did not exhibit any behaviors or rejection of care. He/she indicated it was very important to have a snack available between meals. The resident did not require any assistance with eating. The resident did not have any difficulty swallowing. The resident did not have any oral or dental abnormalities. During the 7-day look back period, the resident received an antidepressant for 7 days. The resident required extensive assistance with transfers with two staff. During the 5-day look back period the resident had experienced pain almost constantly which limited his/her day-to-day activities. His/her pain had made it difficult to sleep at night. He/she admitted on 3/4/14.

Review of the Nutritional Status CAA (Care Area Assessment) dated 3/11/14 revealed the resident was at risk for altered nutrition due to diabetes and ESRD.

Review of the ADL (activities of daily living) Functional/Rehabilitation Potential CAA dated 3/11/14 revealed the resident required assistance to reposition and transfer due to pain and reluctance to move.

Review of the Fall CAA dated 3/11/14 revealed the resident required assistance for transfers.

Review of the Pain CAA dated 3/11/14 revealed the resident had pain.

Interview on 4/24/14 at 2:02 p.m. with

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administrative nursing staff A revealed the purpose of the CAA was to help with the development of the care plan and he/she would have to defer all other questions to administrative nursing staff G, as that was about all he/she knew about them.

Interview on 4/24/14 at 2:10 p.m. with administrative nursing staff G revealed the purpose of the CAA was to determine why the area had triggered. Staff G reported after an area triggered, he/she went through the CAA worksheet and checked the boxes that applied and then wrote a sentence or two about why they triggered. Staff G reported he/she did not complete an individualized CAA summary.

Review of the Resident Assessment Instrument (RAI) 3.0 Manual revealed the CAA documentation helped to explain the basis of the care plan by showing how the interdisciplinary team determined the underlying causes, contributing factors, and risk factors related to the care area for a specific resident.

The facility indicated they did not have a policy regarding CAAs and instead used the RAI Manual.

The facility failed to complete the CAAs to include individualized underlying causes, contributing factors, and risk factors for this resident.

- Review of resident #54's Admission MDS (minimum data set) dated 1/6/14 revealed the resident had a BIMS (brief interview of mental status) score of 15 which indicated no cognitive impairment. The resident had an indwelling urinary catheter, had a risk of developing a

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pressure ulcer and had one or more pressure ulcers.

The Urinary Incontinence and Indwelling Catheter CAA dated 1/6/14 revealed the resident had the use of an indwelling urinary catheter and will need multidisciplinary care planning to monitor for adverse effects associated with catheter use.

The 14 day MDS assessment dated 1/13/14 revealed the resident had BIMS of 15, which indicated no cognitive impairment. The resident had the use of an indwelling urinary catheter.

Interview on 4/24/14 at 2:02 p.m. with administrative nursing staff A revealed the purpose of the CAA was to help with the development of the care plan and he/she would have to defer all other questions to administrative staff G, as that was about all he/she knew about them.

Interview on 4/24/14 at 2:10 p.m. with administrative staff G revealed the purpose of the CAA was to determine why the area had triggered. Staff G reported after an area triggered, he/she went through the CAA worksheet and checked the boxes that applied and then wrote a sentence or two about why they triggered. Staff G reported he/she did not complete an individualized CAA summary.

Review of the Resident Assessment Instrument (RAI) 3.0 Manual revealed the CAA documentation helped to explain the basis of the care plan by showing how the interdisciplinary team determined the underlying causes, contributing factors, and risk factors related to the care area for a specific resident.

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The facility indicated they did not have a policy regarding CAAs and instead used the RAI Manual.

- Review of resident #54's admission MDS (minimum data set) dated 1/6/14 revealed the resident's height on admission was 67 inches and his/her weight was 112 pounds. The resident had weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months. It was documented on the annual MDS that the resident was on physician prescribed weight loss regimen.

The nutrition CAA (care area assessment) dated 1/6/14 revealed the resident needed extra nutrition for healing and had poor intake, the resident will need multidisciplinary care planning to assist patient with nutrition needs being met.

Review of the 14 day MDS assessment dated 1/13/14 revealed the resident had BIMS of 15. It was documented the resident had a weight loss of 5% or more in the last month or 10% or more in the last 6 months. It was also documented on the 14 day MDS the resident remained on a physician prescribed weight loss regimen.

Interview on 4/24/14 at 2:02 p.m. with administrative nursing staff A revealed the purpose of the CAA was to help with the development of the care plan and he/she would have to defer all other questions to administrative staff G, as that was about all he/she knew about them.

Interview on 4/24/14 at 2:10 p.m. with administrative staff G revealed the purpose of the CAA was to determine why the area had

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triggered. Staff G reported after an area triggered, he/she went through the CAA worksheet and checked the boxes that applied and then wrote a sentence or two about why they triggered. Staff G reported he/she did not complete an individualized CAA summary.

Review of the Resident Assessment Instrument (RAI) 3.0 Manual revealed the CAA documentation helped to explain the basis of the care plan by showing how the interdisciplinary team determined the underlying causes, contributing factors, and risk factors related to the care area for a specific resident.

The facility indicated they did not have a policy regarding CAAs and instead used the RAI Manual.

Interview on 4/24/14 at 2:02 p.m. with administrative nursing staff A revealed the purpose of the CAA was to help with the development of the care plan and he/she would have to defer all other questions to administrative staff G, as that was about all he/she knew about them.

Interview on 4/24/14 at 2:10 p.m. with administrative staff G revealed the purpose of the CAA was to determine why the area had triggered. Staff G reported after an area triggered, he/she went through the CAA worksheet and checked the boxes that applied and then wrote a sentence or two about why they triggered. Staff G reported he/she did not complete an individualized CAA summary.

The facility failed to include assessment information that identifies the resident's functional

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F 272	Continued From page 21 capacity and health status into the care area assessment.	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: The facility census totaled 11 with 13 in the sample, 10 current residents and 3 closed	F 278		5/9/14

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records. Three residents were reviewed for comprehensive assessments. Based on observation, interviews and record reviews the facility failed to ensure the MDS (minimum data set) contained accurate information for 2 of the residents. (#54 and #37 for nutrition).

Findings included:

- Review of resident #54's admission MDS (minimum data set) dated 1/6/14 revealed the resident had a BIMS (brief interview of mental status) score of 15, which indicated no cognitive impairment. The resident's height was 67 inches, and his/her weight was 112 pounds. The resident had a weight loss of 5% or more in the last month or a loss of 10% or more in the last 6 months. The documentation showed the resident was on a physician prescribed weight loss regimen.

The Nutrition CAA dated 1/6/14 revealed the resident had a need for extra nutrition for healing, the resident had poor intake and needed multidisciplinary care planning to assist patient with nutrition needs being met.

Review of the 14 day MDS assessment dated 1/13/14 revealed the resident had a BIMS of 15. The MDS also showed a documented weight loss of 5% or more in the last month or 10% or more in the last 6 months. The MDS documented the resident remained on a physician prescribed weight loss regimen.

An interview with Administrative nursing staff G on 4/24/14 at 3:19 p.m. confirmed the resident was not on a physician prescribed weight loss program although it was documented that way on the admission and 14 day MDS. Staff G reported

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he/she just marked it incorrectly.

Review of the RAI (resident assessment instrument) manual stated the MDS must be accurate as of the ARD (assessment reference date).

The facility failed to ensure the MDS contained accurate information to reflect the resident's condition at the time of the assessment.

- Review of resident #37's admission MDS (Minimum Data Set) dated 3/11/14 revealed a BIMS (Brief Interview for Mental Status) score of 15, indicating no cognitive impairment. He/she had a total mood severity score of 05, indicating mild depression. The resident did not exhibit any behaviors or rejection of care. He/she indicated it was very important to have a snack available between meals. The resident did not require any assistance with eating. The resident did not have any difficulty swallowing. The resident did not have any oral or dental abnormalities. During the 7-day look back period, the resident received an antidepressant for 7 days. The resident required extensive assistance with transfers with two staff. During the 5-day look back period the resident had experienced pain almost constantly which limited his/her day-to-day activities. His/her pain had made it difficult to sleep at night. He/she admitted on 3/4/14.

Review of the Nutritional Status CAA (Care Area Assessment) dated 3/11/14 revealed the resident was at risk for altered nutrition due to diabetes and ESRD (End-stage Renal Disease-a terminal

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disease because of irreversible damage to the kidneys).

Review of the ADL (activities of daily living) Functional/Rehabilitation Potential CAA dated 3/11/14 revealed the resident required assistance to reposition and transfer due to pain and reluctance to move.

Review of the Fall CAA dated 3/11/14 revealed the resident required assistance for transfers.

Review of the Pain CAA dated 3/11/14 revealed the resident had pain.

Review of the 30-day MDS dated 4/1/14 revealed a BIMS score of 15, indicating no cognitive impairment. He/she had a total mood severity score of 12, indicating moderate depression. The resident did not exhibit any behaviors or rejection of care. The resident did not require any assistance with eating. The resident did not have any difficulty swallowing. The assessment identified no weight loss in the last month of 5% or more. The resident did not have any oral or dental abnormalities. During the 7-day look back period, the resident received an antidepressant for 6 days. The resident had total dependence on 2 staff with transfers. During the 5-day look back period, the resident had experienced pain almost constantly and the resident reported his/her pain had limited day-to-day activities. His/her pain had made it difficult to sleep at night.

Interview on 4/24/14 at 5:45 p.m. with administrative nursing staff A revealed he/she did not know of any issues with MDS accuracy.

Review of the Resident Assessment Instrument

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F 278	Continued From page 25 (RAI) 3.0 Manual revealed when coding weight loss on the MDS, the resident's weights needed to be mathematically rounded to the nearest whole pound before completing the significant weight loss calculation. Then the assessment needed to be coded that the resident had not experienced a significant weight loss, the resident had experienced a significant weight loss, but the resident was on a physician-prescribed weight-loss regimen, or the resident had experienced a significant weight loss and the resident did not have a physician-prescribed weight-loss regimen. The facility indicated they did not have a policy regarding the MDS and instead used the RAI Manual. The facility failed to accurately document the resident's weight loss of 5% on the MDS.	F 278		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: The facility census totaled 11 residents; the sample size consisted of 13 residents, 10 in the facility and 3 discharged residents. One resident was reviewed for ADLs (activities of daily living). Based on the record review, observation and interview, the facility failed to provide assistance	F 312		5/29/14

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as indicated by the resident's ability to achieve and maintain the highest practicable outcome. (#68)

Finding included:

- Review of resident #68's signed physician order sheet dated 4/11/14 revealed the resident had a diagnosis of weakness.

Review of the resident's admission assessment dated 4/11/14 revealed the resident was alert and oriented to person, place, time and event. He/she had his/her natural teeth, some missing teeth, and a bottom left tooth that had been previously pulled. The assessment identified the resident as confused at times, unable to make own needs known and under the musculoskeletal portion identified the resident as dependent on staff for ADLs.

Review of the care plan dated 4/11/14 revealed there was no care plan for ADLs related to dental care.

Review of the signed physician's orders dated 4/11/14 revealed the resident could keep personal care/grooming items at bedside.

Review of the ADL documentation from 4/11/14 to 4/24/14 revealed no oral care documentation in the ADL section on the facility's computer charting system.

Observation on 4/23/14 at 7:45 a.m. revealed the resident lay in bed. Next to the sink lay a toothbrush in an unopened package and opened mouthwash.

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Observation of the resident's mouth on 4/23/14 at 12:16 p.m. revealed multiple carious teeth, multiple areas of black spots on the teeth, and in the back, left bottom an area where a tooth was pulled.

An interview with the resident on 4/22/14 at 1:40 p.m. revealed the resident used swish and spit solution and stated he/she did not have a toothbrush. At 1:53 p.m. he/she stated staff cleaned his/her teeth/mouth weekly.

An interview on 4/23/14 at 12:44 p.m. with Direct care staff B revealed the direct care staff helped residents set up with their personal hygiene items. If the resident was unable to brush his/her own teeth the aide would do it for them. Staff B stated that the resident was capable of brushing his/her own teeth. Staff gave the resident a kidney basin and a cup to brush his/her teeth. The aides documented in ADLs and in their charting that the teeth were brushed. Staff B confirmed the resident did not get his/her teeth brushed that morning. Staff B stated that the resident had a toothbrush and toothpaste in his/her room.

An interview on 4/23/14 at 3:13 p.m. with Direct care staff H revealed the amount of assistance staff provided depended on how much help the resident needed. Staff H stated that the resident could not brush his/her own teeth. Staff H stated that staff brushed the resident's teeth at least once a day before they went to bed. Staff H stated he/she did not know of any dental problems. Staff reported he/she reported problems to the nurse, if noted. Staff H stated that the resident did not complaint of dental issues. Staff H stated that oral care was

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documented in ADL section of the facility's charting.

An interview on 4/23/14 at 4:12 p.m. with Licensed nursing staff I revealed he/she expected aides to brush a resident's teeth if the resident could not do it on his/her own and expected the aides to do so without being told. Staff I stated the resident brushed his/her own teeth. Staff I expected oral care to be charted if the aides did it or the resident did it.

An interview on 4/24/14 at 9:47 a.m. with Licensed nursing staff E revealed he/she expected resident's teeth to be brushed at least once a day and that it should just be done automatically. Staff E stated the resident did not complain about issues related to his/her teeth, the resident received nystatin (oral medication for the treatment/prevention of an infection of the mouth/throat producing whitish patches).

An interview on 4/24/14 at 5:25 p.m. with Administrative nursing staff A revealed the CNA should provide oral care and if the resident could not get out of bed the CNA should perform oral care at minimum twice a day. Staff A stated oral care did not get care planned because of short stay residents. Oral care got documented by the CNAs in the ADL section, when complete. Staff A confirmed that the resident did not receive oral care in the last week.

Review of the Oral care for non-trached/non vented patients policy dated 1/12 revealed the frequency of oral care varied depending upon the resident's condition. All residents at least twice daily and as needed, family members would be instructed and encouraged to assist their family

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F 312	Continued From page 29 member in oral hygiene and ancillary staff, including respiratory therapist and speech therapists may perform oral care as appropriate and within their scope of practice. The admission assessment included condition of teeth and gums and self care ability, subsequent assessments would be tailored to each resident. The policy also stated that oral care and resident tolerance be recorded in the electronic medical record. The facility failed to provide assistance needed to help the resident care for his/her teeth and maintain the resident's ability to function.	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: The facility census totaled 11 residents with 13 included in the sample. Based on observation, interview, and record review the facility failed to develop and implement interventions to prevent the developement of an unstageable pressure ulcer for one of one resident sampled for pressure ulcers #76. Findings included:	F 314		5/29/14

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- Review of resident #76's closed record included diagnoses from the signed History and Physical from 4/6/14 revealed the resident had diagnoses of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, forward flexion of the trunk, loss of postural reflexes and muscle rigidity and weakness), and type II diabetes (when the body cannot use glucose, there is not enough insulin made or the body cannot respond to the insulin).

Review of the nursing admission assessment dated 4/10/14 revealed no documentation of a right heel unstageable (full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (dead tissue, usually cream or yellow in color) and /or eschar (dead tissue with a hard outer covering, usually brown or black in color) in the wound bed) pressure ulcer. The assessment revealed the resident was alert and oriented to person, place, time, and situation. The Braden scale (an assessment for pressure ulcer risk) score upon admission was 20 indicating the resident did not have increased risk for skin breakdown. The resident had warm and dry skin with decreased elasticity to turgor and moist mucus membranes. The resident required assistance of two staff with a walker for mobility and had a weak gait and transferring ability.

Review of the resident's hospital discharge summary from 4/10/14 lacked documention of any skin breakdown to the resident's heels.

Review of the nursing shift assessments from 4/10/14 to 4/14/14 revealed staff identified a right heel unstageable pressure ulcer initially on

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F 314	Continued From page 31 4/14/14. Review of the resident's initial care plan dated 4/10/14 revealed an integumentary (skin) care plan related to erythema of skin folds with the goal of no skin breakdown. Interventions directed staff to monitor skin daily, and turn and reposition the resident at least every two hours. The care plan lacked further interventions for pressure ulcer prevention or healing. Review of the Wound and Skin Recommendations from the initial wound and skin consult dated 4/15/14 revealed interventions directed staff to reposition the resident every two hours from left to back to right per the written turning schedule, float the resident's heels (have the heels in the air with nothing touching them), use backless shoes to the right foot, and change the dressings to the right foot daily. Detailed directions for dressing changes followed the interventions. Staff documented education for the resident via discussion, demonstration, and handouts on activity and to get up to his/her chair for meals, to continue a regular diet, and about pressure ulcer prevention which included mobility. The care plan lacked revision to include the interventions put in place when the resident developed a pressure ulcer. Review of the clinical nurse note on 4/14/14 at 4:00 PM revealed staff noted an open area to the resident's right heel. It appeared that a blister had opened and the skin was gone. The skin that remained intact appeared as if it soaked in water too long and looked moist. The area of heel missing skin appeared red in color and contained a centrally purple area. The area felt mushy to the	F 314		

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touch. The patient denied pain or discomfort. Staff consulted the wound and skin team via protocol. The wound nurse called with dressing recommendations and staff applied a dressing to the site as indicated. Staff floated the resident's heels.

Review of the clinical nurse note dated 4/15/14 at 9:45 AM revealed staff changed the right heel dressing at that time per the recommendations. The center of wound no longer appeared dark in color. Staff continued to float the heels on 2 pillows to prevent pressure.

Review of the wound and skin nursing note dated 4/15/14 at 12:15 PM revealed the wound care nurse saw the resident for newly developed pressure ulcer to the right posterior (the back part) plantar (of or relating to the sole of the foot) heel that appeared as an erupted bulla (a bubble like cavity filled with air or fluid) with a darkened center representing an unstageable pressure ulcer. The patient had a diagnosis of diabetes and presented with advanced neuropathy (disease or dysfunction of one or more peripheral nerves, typically causing numbness or weakness) and edematous (swelling resulting from an excessive accumulation of fluid in the body tissues) extremities. Nursing staff had noted the issue of the resident's right heel on 4/14/14 in the afternoon and placed dressing for protection. The wound nurse provided care to the resident's wounds and left detailed directions for floor staff concerning dressing changes. Staff took photographs and wound measurements. The area to the right heal measured 3.9 cm (centimeters) x 4.3 cm with a depth of 0.05 cm.

Review of the clinical nurse note dated 4/17/14 at

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2:00 PM revealed staff changed the dressing to the right heel per the wound and skin care instructions. The area of the right heel appeared raw and drained serosanguineous fluid (wound drainage of a semi-thick reddish color). The patient denied pain.

Review of the clinical nurse note dated 4/19/14 at 8:05 PM revealed staff changed the resident's dressing at 11:30 AM. The staff elevated the resident's feet and removed his/her socks to prevent pressure.

Review of the clinical nurse note from 4/20/14 at 1:02 AM revealed the patient's right heel dressing remained intact and dry.

Review of the clinical nurse note dated 4/20/14 at 6:29 AM revealed the nurse applied a new dressing to the right heel. Staff elevated the resident's legs up on pillows.

Review of the clinical nurse note dated 4/20/14 at 4:42 PM reveal the patient refused to sit in his/her chair during meals that day. He/she requested to stay in bed. Staff elevated the resident's heels to prevent further breakdown. The night shift nurse changed the resident's dressing and it appeared dry and intact.

Review of the clinical nurse note dated 4/21/14 at 2:28 PM revealed staff changed the dressing to right foot per the protocol on the chart. Staff continued to float the resident's heels.

Review of the clinical nurse note dated 4/21/14 at 6:54 PM revealed the wound care nurse came and assessed the right heel. He/she then changed the dressing on the right heel so that

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he/she could see the wound. The wound nurse said to continue with the dressing protocol as written in the chart.

Review of the wound and skin nursing note dated 4/21/14 at 4:25 PM revealed the wound nurse saw the resident to reassess the pressure ulcer to the right heel. The area to the right heel measured 3.7 cm x 3.7 cm and remained unstageable.

Review of the physician orders on admission, 4/10/14, revealed the resident received a regular diet. On 4/14/14 the resident's diet was changed to a regular diet with Carnation Instant breakfast (a nutritional supplement). The order specified the resident required 2000 calories daily with 30% of the calories from fat, 20% of the calories from protein, and approximately 3 grams of sodium.

Review of the resident's laboratory results revealed an Albumin (a blood test used to measure the amount of protein in the blood and is used in part to determine a person's nutritional status) level was checked on 4/10/14 and resulted in a low level as 2.5 gm/dl (grams per deciliter), with as reference range of 3.4-5 gm/dl. On 4/1/14 the albumin level remained the same, 2.5 gm/dl, and on 4/17/14 the Albumin level was 2.4 gm/dl. A Total Protein level was assessed on 4/10/14 and resulted in a low level as 6.0 gm/dl with a reference range of 6.4-8.2 gm/dl. Levels were also checked on 4/13/14 and resulted as 6.1 gm/dl and on 4/17/14 as 5.9 gm/dl.

Interview on 4/23/14 at 11:00 AM with direct care staff B revealed he/she was not sure if the resident came into the facility with the pressure sore. He/she stated the resident required

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assistance with cares due to Parkinson's disease, and the resident required a maximum assist of 2 people to the bedside commode. The resident could stand and transfer at times, but mostly the resident just pivoted due to weakness in his/her legs. Staff B reported interventions to prevent skin breakdown included floating the resident's heels, and assisting to turn every 2 hours. The resident did not have any other skin breakdown to staff B's knowledge.

Interview on 4/23/14 at 4:16 PM with licensed staff C revealed that the resident had a pressure ulcer to the right heel. He/she reported that the nurse that did the admission assessment did not notice the pressure ulcer so it may have developed at the facility. The resident also had some foot drop. Staff C reported interventions for preventing skin breakdown consisted of keeping the heels as elevated as possible. The nursing staff performed daily dressings per the wound nurse recommendations. Staff C reported that on Monday the wound nurse rounded and evaluated the ulcer, and reported to him/her that the ulcer had improved.

Interview on 4/24/14 at 3:15 PM with direct care staff D revealed he/she did not remember the specific resident, but pressure ulcer prevention included keeping pressure off the affected area through turning and pillow support. If the resident exhibited a heel ulcer he/she would elevate the resident's leg so the heel did not touch the bed. If he/she noticed any redness to an area he/she would notify the nurse right away.

Interview on 4/24/14 at 11:45 AM with licensed care staff E revealed the pressure ulcer to the resident's heel was not present on admission.

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Staff implemented floating the resident's heels on one pillow upon admission and after the pressure ulcer developed staff floated the resident's heels on two pillows. The resident usually complied with the elevation of his/her heels but had some foot drop and by the last few days he/she asked for just one pillow and refused the two.

Interview on 4/24/14 at 5:19 PM with licensed care staff E revealed he/she looked at the care plans daily and updated them as needed.

Interview on 4/24/14 at 5:20 PM with licensed staff F revealed he/she looked at the care plans daily usually during shift report, and he/she updated them as needed.

Interview with administrative nursing staff A on 4/24/14 at 3:47 PM revealed the nursing staff could initiate a wound team consult at any time. Staff performed Braden assessments routinely on residents. Staff A reported if the resident scored certain points then based on the score the staff initiated interventions such as to float heels, or order a low pressure air loss mattress. With residents that scored a moderate risk per the Braden score staff utilized a turn clock for the residents. Staff placed the clock in the room to remind them to turn the resident at least every two hours and a clock magnet was placed on the door frame. With a wound and skin consult staff followed the wound and skin nurses' prescription for wound care. Staff A reported other important prevention activities for skin breakdown included good pericare, foot care, floating the resident's heels, and turning the resident. Identification of at risk residents would be primarily based off the Braden score and physical assessment. The care plan should be updated when a resident was

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identified as being at risk for or having skin breakdown. Care plans could be updated by floor nurses or the wound care nurse. Staff A looked at the resident's hospital admission to make sure that the pressure ulcers were not just an assessment error and found that the resident was admitted to the hospital on 4/6/14. Staff scored the resident with a Braden score of 16 which indicated at risk for pressure ulcers. The hospital's charting lacked documentation of a right heel pressure ulcer. After review of the data in the computer chart Staff A confirmed that the right heel pressure ulcer developed at the facility.

Interview with the physician on 4/29/14 at 2:17 PM failed to provide any additional information.

Review of the facility's Maintaining Skin Integrity and Pressure Ulcer Prevention, revised 4/12, revealed the facility assessed each resident's skin on admission, every shift after, and upon transfer to another unit. The facility considered the following risk factors for pressure ulcer development: Braden Scale score of less than or equal to 18, resident history and clinical factors such as a healed pressure ulcer, high or low body mass index, advanced age, medical devices, certain medical diagnoses that limited blood flow or oxygenation to the skin or extremities, and loss of protective sensation, ability to perceive pain, or respond in an effective manner. The facility implemented appropriate interventions for residents at risk of skin damage. The policy directed staff to place a wound and skin consult upon identification of a pressure ulcer for accurate staging or for additional assistance in wound identification.

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F 314	Continued From page 38 The facility failed to develop and implement interventions to prevent the developement of an unstageable pressure ulcer.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: The facility census totaled 11 residents with 13 in the sample and 3 of the residents in the sample were closed records. Based on observation, interview, and record review the facility failed to have appropriate indications for urinary catheters for 3 of 3 residents (#54, #72, #50). Findings included: - Review of #72's General Nursing Admission Assessment dated 4/14/14 revealed the resident as alert and oriented to person, place, time, and event. The resident required partial assistance of 1 staff member using a walker for transfers. He/she had impaired gait and transferring status. He/she had a 16 F (French, size of catheter) urinary catheter in place requested by the resident/family for improved comfort.	F 315		5/29/14

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Review of a Nursing Shift Assessment dated 4/23/14 revealed the resident as alert and oriented to person, place, time, and event. He/she required partial assistance of 2 staff members during transfers. He/she had impaired gait and transferring and had a 16 F urinary catheter.

Review of the resident's care plan initiated 4/14/14 revealed interventions directed staff to identify risk factors, provide a safe and caring environment, and provide catheter care per protocol.

Review of a signed Admission Order sheet dated 4/14/14 revealed an order for urinary catheter as needed and per the resident's request.

Observation on 4/23/14 at 7:53 a.m. revealed the resident had a catheter bag.

Interview on 4/23/14 at 11:02 a.m. with the resident revealed he/she had the catheter placed when he/she first came into the facility. The resident stated if he/she had to get up and go to the bathroom he/she would not be able to make it. At 11:55 a.m., the resident reported the staff emptied the catheter bag when full.

Interview on 4/23/14 at 3:36 p.m. with licensed nursing staff C revealed the catheter had been in place since 4/11/14.

Interview on 4/24/14 at 3:55 p.m. with licensed

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nursing staff F revealed there had to be an order for a urinary catheter if the resident had one in place on admission. He/she revealed the order should have a diagnosis that indicated the reason for the use of the urinary catheter. He/she reported acceptable uses for urinary catheter would be for acute urinary retention or by the resident's request for comfort. He/she reported incontinence alone would not be an acceptable use of a urinary catheter. Staff F reported the staff assessed the residents daily for the necessity of the catheter placement. He/she reported most residents only had a urinary catheter for a few days prior to receiving an order to remove it.

Interview on 4/24/14 at 4:11 p.m. with administrative nursing staff A revealed he/she expected staff to assess the resident twice a day, and at a minimum, assess the resident's catheter daily for continued need.

Interview on 4/24/14 at 5:47 p.m. with administrative nursing staff A revealed the facility followed the CAUTI (Catheter Associated Urinary Tract Infections) initiative which indicated appropriate uses of urinary catheters to be during selective surgical procedures, the management of acute urinary retention, assistance in pressure ulcer healing for incontinent residents, the need for accurate output monitoring in critically ill residents in the ICU (intensive care unit); intake and output monitoring, in intubated (the placement of a flexible plastic tube into the trachea (windpipe) to maintain an open airway), sedated or paralyzed residents or residents on a vasopressor (any medication that tends to raise reduced blood pressure), chronic indwelling

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catheter use, when requested by the resident or family to improve comfort, and to improve comfort at the end of life. Staff A revealed he/she expected staff to evaluate for the removal of a urinary catheter for residents who were admitted with a catheter that remained in longer the 3 days and discuss with the resident's physician.

Review of the facility's policy for Prevention of Catheter Associated Urinary Tract Infections (CAUTI), last revised 11/13, revealed all urinary catheters were inserted with a physician order and the order should include the indication for the catheter. The policy also stated that all nurses were to assess the residents daily for continued urinary catheter need and that staff were to provide urinary care twice daily and as needed for soiling. If an indication for the indwelling catheter to continue was no longer present the nurse will contact the physician and ask for a discontinue order. If there was no indication for the indwelling catheter associated with the order or in the progress notes the nurse contacted the physician for an indication.

The facility failed to identify appropriate indication for use of the indwelling catheter for resident #72.

- Review of the closed record for resident #50 revealed from the hospital's physician discharge summary on 12/24/13 diagnoses that included a closed fracture (broken bone) of the femur (the thigh bone), UTI (urinary tract infection) secondary to a fall, and Parkinson's Disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, forward flexion of the trunk, loss of postural reflexes and muscle rigidity and weakness). Review of

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diagnoses from a consult on 12/24/13 revealed the resident also had history of abnormal weight loss, and Congestive Heart Failure (a condition when the heart output is low and the body becomes congested with fluid).

Review of the admission Minimum Data Set (MDS) dated 12/31/13 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14 which indicated cognitively intact. The resident had a mood score of 5 which indicated mild depression. The resident required limited assistance with bed mobility, extensive assistance with transfers and walking in the room, and total dependence of staff with locomotion on and off the unit. The resident had an indwelling urinary catheter and staff had not attempted a urinary toileting program. The resident was admitted to the facility on 12/24/13.

Review of the Urinary Incontinence CAA dated 1/5/14 revealed the resident had an indwelling urinary catheter with a UTI and needed assistance to understand the need to have the catheter removed as soon as medically indicated to minimize untoward effects of catheter use.

Review of the resident's initial care plan dated 12/24/13 revealed staff initially placed the urinary catheter on 12/19/14 during the resident's hospital stay for accurate intake and output measurements. The reason for the continued use of the catheter upon admission was per resident request due to 2 recent surgeries and the resident had difficulty with transferring. Staff documented a goal of discontinuing the urinary catheter as soon as medically indicated with an intervention that directed staff to discontinue the

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catheter as soon as able.

Review of the admission orders dated 12/24/13 revealed the physician checked the box indicated on the order summary to continue urinary catheter use, but the order lacked justification of use.

Review of the resident's admission assessment report dated 12/24/13 revealed the indwelling urinary catheter was required for accurate intake and output monitoring, and/or requested by the patient or the patient's family to improve comfort. The facility did not provide an order to accompany this indication.

Review of the physician orders dated 1/11/14 revealed an order to discontinue the urinary catheter.

A clarification order for justification of catheter was requested from the facility on 4/24/14 at 3:00 PM. The facility did not provide any additional signed physician orders relating to the catheter.

Interview on 4/24/14 at 3:55 PM with licensed nursing staff F revealed the facility had to have an order for a catheter if the resident came to the facility with it. Staff F reported the order needed to have a diagnosis that indicated the use of the catheter. Staff F reported acceptable reasons for catheter use would be acute urinary retention or resident or family requests. Staff F reported incontinence alone would not an acceptable use of urinary catheter and staff were expected to assess the need for the continued use of the catheter. Staff F reported staff assessed continually if the resident still had urinary retention or problems voiding. Staff F reported the resident

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had a catheter for a long time, but he/she did not know the specific indications for use, and it may have been a necessity. Staff F reported if the physician had justification for keeping the urinary catheter, then it would not be a problem. Staff F reported most residents only had a catheter for a few days before staff removed the catheter.

Interview on 4/24/14 at 4:11 p.m. with administrative nursing staff A revealed he/she expected staff to assess the resident's catheter daily for continued use.

Interview on 4/24/14 at 5:47 p.m. with administrative nursing staff A revealed the facility followed the CAUTI (Catheter Associated Urinary Tract Infections) initiative which indicated appropriate uses of urinary catheters to be during selective surgical procedures, the management of acute urinary retention, assistance in pressure ulcer healing for incontinent residents, the need for accurate output monitoring in critically ill residents in the ICU (intensive care unit); intake and output monitoring, in intubated (the placement of a flexible plastic tube into the trachea (windpipe) to maintain an open airway), sedated or paralyzed residents or residents on a vasopressor (any medication that tends to raise reduced blood pressure), chronic indwelling catheter use, when requested by the resident or family to improve comfort, and to improve comfort at the end of life.

Review of the facility's policy for Prevention of Catheter Associated Urinary Tract Infections (CAUTI), last revised 11/13, revealed all urinary catheters were inserted with a physician order and the order should include the indication for the catheter. The policy also stated that all nurses

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were to assess the residents daily for continued urinary catheter need. If an indication for the indwelling catheter to continue was no longer present the nurse would contact the physician and ask for a discontinue order. If there was no indication for the indwelling catheter associated with the order or in the progress notes the nurse contacted the physician for an indication.

The facility failed to ensure the resident's indwelling urinary catheter had an appropriate indication for use.

- Review of the closed record for resident #54 revealed an Admission MDS (minimum data set) dated 1/6/14 revealed the resident had a BIMS (brief interview of mental status) score of 15 which indicated no cognitive impairment. The resident had an indwelling urinary catheter, had a risk of developing a pressure ulcer.

The Urinary Incontinence and Indwelling Catheter CAA dated 1/6/14 revealed the resident had the use of an indwelling urinary catheter.

The 14 day MDS assessment dated 1/13/14 revealed the resident had BIMS of 15 and the resident had the use of an indwelling urinary catheter.

Review of the care plan dated 12/30/13 revealed the resident had an indwelling urinary catheter; interventions directed staff to identify risk factors and provide a safe, caring environment.

Review of the nursing shift assessment dated 12/31/13 revealed a catheter was in place, reason for insertion was assistance in pressure ulcer healing for incontinent residents, reasons

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for continuation of catheter use were indwelling catheter indicate to maintain physician intake and output, to promote wound healing in the incontinent resident, unable to void due to immobility (example: acute hip or pelvic fracture).

Review of nurses' notes dated from 1/1/14 to 1/17/14 revealed the resident continued with the indwelling urinary catheter.

A nursing shift assessment dated 1/24/14 revealed the reason for insertion of the catheter as assistance in pressure ulcer healing for incontinent patients and the reason for continued use to promote wound healing in the incontinent patient.

An interview on 4/23/14 at 12:44 p.m. with Direct care staff B revealed he/she remembered the resident had a catheter but did not know why.

An interview on 4/23/14 at 3:23 p.m. with Direct care staff H revealed the resident had a catheter. Staff H did not know why the resident had a catheter.

An interview on 4/24/14 at 4:54 p.m. with Licensed nursing staff E revealed residents could come from the hospital with a catheter, if they did not have a diagnosis the nurse needed to call the physician within the day to get an order for the catheter. The facility's protocol directed licensed nurses to try to discontinue a catheter. The nurses monitored the need, continuation and reasoning for keeping a catheter every 24 hours.

An interview on 4/24/14 at 5:25 p.m. with Administrative nursing staff A revealed all catheters must have an indication for use. The

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F 315	Continued From page 47 catheter need was assessed every 24 hours. On 4/24/14 at 4:58 p.m. Staff A confirmed the chart lacked an order for the resident to have a catheter. Review of the facility's policy for Prevention of Catheter Associated Urinary Tract Infections (CAUTI), last revised 11/13, revealed all urinary catheters were inserted with a physician order and the order should include the indication for the catheter. The policy also stated that all nurses were to assess the residents daily for continued urinary catheter need. If an indication for the indwelling catheter to continue was no longer present the nurse was to contact the physician and ask for a discontinue order. If there was no indication for the indwelling catheter associated with the order or in the progress notes the nurse contacted the physician for an indication. The facility failed to have an order for the catheter use and a medical justification to keep the catheter in place.	F 315		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371		5/9/14

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by:
The facility census totaled 11 residents. The facility reported all residents received food from the main kitchen. Based on observation, interview, and record review, the facility failed to ensure staff that handled foods used adequate hair restraints during food preparation. This failure had the potential to affect all residents.

Findings included:

- Observation on 4/24/14 at 11:47 a.m. revealed multiple dietary staff members at various stations in the kitchen preparing and plating food to serve to the residents. Ten of those dietary staff members wore hair restraints that did not contain or restrain the root of the hair. One dietary staff had a large portion of bangs hanging out of the front of the hair net, another staff member did not have a beard covering for a goatee, and the other 8 dietary staff members had hair restraints on, but hair hung out from the back and sides of the hair restraints.

Interview on 4/24/14 at 11:57 a.m. with dietary staff K revealed all persons entering the kitchen needed to wear hair coverings and he/she expected all hair to be covered. Staff K reported there were signs posted at the doors alerting staff to put on a hair covering prior to entering the kitchen.

Review of the facility policy for Unauthorized Traffic Through Food Service, revised 6/27/12, revealed hair coverings were to be worn at all times.

The facility failed to ensure adequate hair restraints were used by 10 dietary staff members

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F 371	Continued From page 49 while preparing and plating food.	F 371		